Guide to Chapter 5

CHAPTER 5

Factors to Consider When Choosing Coverage Options: Two Illustrative Services[1]

As is clear from Chapter 4's discussion, Medicaid provides multiple coverage alternatives for some services. The advantages and disadvantages of each may not be apparent until the state works through their different implications in the context of its own unique long-term care service system. This chapter provides guidance to states as they weigh the tradeoffs among different coverage alternatives for a particular service. To provide enough specificity to be useful, the discussion covers two particular service options: (a) case management/service coordination and (b) services provided to elderly persons in assisted living settings.

Introduction

When a state is faced with several alternative ways of covering a particular home and community service, the tasks of (a) choosing among different coverage alternatives and (b) defining the precise service require detailed analysis of each alternative in the context of a state's home and community system's service needs. This chapter illustrates the types of issues to be considered with two specific services: case management and assisted living.

Case management is chosen as the first illustration because it is the backbone of the formal long-term care delivery system. Its overarching purpose is to facilitate Medicaid beneficiaries' access to the direct services they need. Every state offers case management in some form under its Medicaid program and every state has to decide how best to cover it.

Assisted living is chosen as the second specific service example, because it provides an excellent illustration of the complex issues involved in defining a service so as to ensure its maximum usefulness within a particular state system. The focus here is on assisted living services provided under Medicaid to persons age 65 and older. By early 2000, 35 states were serving Medicaid beneficiaries in assisted living settings. Residential care alternatives to institutions have been offered to persons with mental retardation and developmental disabilities for some time. Making them available to elderly persons is a more recent, and less well understood, initiative.[2]

Coverage of Case Management: Illustration #1

Medicaid gives states three ways to cover case management services: 1) targeted case management, (2) HCBS waiver programs, and (3) administrative claiming.[3] This section discusses the advantages and

disadvantages of each option in obtaining Federal financial participation (FFP).

Targeted Case Management Services

A state may claim FFP for case management services under its Medicaid plan by offering them to a defined group of recipients, or to multiple groups as long as different provisions apply to each. For example, a state may offer one form of targeted case management services to recipients who have a mental illness and another to persons who are elderly and have physical impairments. The scope of targeted case management services that may be claimed for FFP can include: (a) conducting assessments, (b) assisting individuals and families to identify needed services and supports (whether the direct services are funded through the Medicaid program or otherwise), and (c) helping them obtain such services. (The State Medicaid Manual contains a thorough discussion of these activities.)

Advantages to states of offering targeted case management services:

- The state is free to define the population that will be targeted.

- These services may be offered to Medicaid eligible persons regardless of whether the person participates in an HCBS waiver program. Consequently, they may be made available without regard to type or funding source to all Medicaid-eligible individuals (including HCBS waiver participants) who need home and community services. This makes targeted case management a potentially very useful coverage option in establishing a broad-based coordinated service system.

- A problem for case management covered under an HCBS waiver program is that FFP is only available once the person has entered the program. Thus, case management costs incurred in advance of enrollment are not eligible for FFP. (Some pre-waiver case management costs may be covered if they are begun before waiver participation but completed on the first day the person is enrolled in the waiver program. See Appendix II for a recent HCFA letter to State Medicaid Directors regarding the earliest date of service for which FFP can be claimed.) Targeted case management services may be furnished irrespective of whether the person is enrolled in an HCBS waiver program, however, enabling most pre-enrollment costs associated with service coordination to be recouped.

- Once states were severely limited in obtaining FFP for targeted case management services furnished to institutionalized persons. Until recently, FFP was available only for services furnished to individuals in the 30-day period immediately preceding the person's discharge from the facility. Now, FFP is available for targeted case management services to assist and arrange for an individual's community transition for up to 180 days preceding discharge. This recent policy clarification by HCFA enables a state to involve community service coordinators earlier in the community placement process. FFP for such targeted case management services is available regardless of whether the person is enrolled upon discharge in an HCBS waiver program, receives other Medicaid home and community services, or is supported through alternative funding sources. However, FFP is not available if the person's community placement does not take place.[4]

- The costs of targeted case management services may be claimed at the service rate, which in many states is significantly higher than the 50 percent rate that applies to administrative claiming (see below).[5]

- The targeted case management option is compatible with state strategies to delegate provision of service coordination through contracts or memoranda of agreement with public or non-public agencies (or multiple sources). This is beneficial where counties are responsible for the provision of case management services. Such strategies can be useful in promoting consumer choice in selecting support coordinators from a variety of sources.

- When the targeted groups are those with serious mental illness or mental retardation and

other developmental disabilities, targeted case management enables a state to limit service providers to the case management authorities already established in state law. This allows states to tie delivery of targeted case management services into their already established single point of entry systems. In contrast, when case management/service coordination is offered under an HCBS waiver program, Medicaid freedom of choice of provider rules apply and a state must enable HCBS waiver participants to obtain case management/service coordination from any qualified provider.

Drawbacks to states of offering targeted case management services:

- Obtaining FFP for targeted case management requires "service claiming" (i.e., claims for reimbursement for a specific service delivered to a specific Medicaid recipient). Service claiming can generate considerable paperwork. It can also pose logistical problems in developing a reimbursement mechanism that enables the relevant authority to maintain base operation levels when the amount of case management varies individual-to-individual, month-to-month. The varying workload problem also arises when service coordination is offered as a distinct service under an HCBS waiver program. There are solutions for this problem, but they can involve their own complications.

- The necessity for service claiming can also make it difficult to obtain reimbursement for activities conducted on behalf of all recipients rather than distinctly for the benefit of a specific individual (e.g., staff development activities for case managers). Again, there are ways to address this problem (mainly through cost-apportionment—see further below under Administrative Claiming).

- Service coordinators often help support individuals in ways that fall outside the scope of targeted case management activities for which FFP may be claimed. FFP for targeted case management services is not available for "direct services." Examples are a case manager's driving an individual to a doctor's appointment (transportation) or helping the person manage their finances. Federal policy dictates that such direct services be claimed via other categories (e.g., making a claim for Medicaid transportation services). Having to assign some of the activities case managers routinely conduct on behalf of individuals to other categories creates administrative and billing complexity.

- Except for targeted case management services furnished to assist or arrange an individual's return to the community (i.e., community transition planning), Federal policy does not permit FFP for targeted case management services furnished to institutionalized persons. This limitation arises from the concern that activities performed for institutionalized persons by case managers not on the facility staff would duplicate activities facilities are required to conduct on behalf of their residents.

- Where a state provides external case management services to institutionalized persons, the general prohibition against FFP for targeted case management services furnished to institutionalized persons can result in a state having to turn to administrative claiming in order to underwrite the costs of external case management activities for institutionalized individuals. The need to employ separate streams for case management services depending on whether or not a person is institutionalized can cause complications for states.

HCBS Waiver Coverage

FFP is available for the costs of case management/service coordination when a state covers such services under its HCBS waiver program. This option differs little from targeted case management with respect to types of activities for which FFP may be claimed. The general interchangeability of these options is illustrated by the fact that all states operate HCBS waiver programs for people with developmental disabilities, but states divide about equally between those that use targeted case management coverage and those that cover service coordination as an HCB waiver service.

However, two significant aspects differentiate case management/service coordination covered as an HCB waiver service from targeted case management coverage:

- Under a waiver, availability of the service is restricted to individuals who are waiver participants.

- Under a waiver, a state may not limit case management service providers to established case management authorities—as it can under the targeted case management option.

Advantages to states of covering case management/service coordination as an HCBS waiver service:

- Covering case management/service coordination as an HCB waiver service tightly links availability of such services to the target population served through the HCBS waiver program. Thus, the scope of such coverage may be tied directly to the specific needs of the waiver population.

- Covering case management as an HCB waiver service enables a state to provide for more intensive service coordination for HCBS waiver participants than it might (for financial reasons) be prepared to offer a wider range of individuals.

Drawbacks to states of offering case management/care coordination as an HCBS waiver coverage:

- The service is limited to individuals enrolled in the HCBS waiver program.

- Claims for FFP may only begin, as noted, once the person has been approved for admission to the waiver program. This prevents the state from being reimbursed for pre-enrollment case management expenses. However, some pre-waiver case management costs may be covered (a) if they are begun before waiver participation but completed on the first day the person enrolls in the waiver, or (b) if they occur in the 180 days preceding transition from an institution to the community.

Administrative Claiming

Administrative claiming takes advantage of a provision in Federal law permitting states to claim FFP for administrative expenses they incur in operating their Medicaid programs. Such expenses may include costs of intake, assessment, service planning, arranging Medicaid services for recipients, and overseeing service delivery—many of the activities typically performed by case managers.

Administrative claiming differs from the targeted case management and waiver alternatives in one important aspect: It may not be used in conjunction with assisting recipients to access non-Medicaid services—even though such services might benefit the recipient. Case managers may work to coordinate access to all services in a care plan. But administrative claiming can only be used for the administration of the Medicaid program, as established by a time study or other method to apportion Medicaid and non-Medicaid costs.

Advantages to states of using the administrative claiming option for case management activities:

- It is not necessary to bill for distinct activities on behalf of specific individuals, because administrative claiming is not service-based. Administrative claiming is usually accomplished by apportioning the costs an organization incurs between those attributable to Medicaid recipients and those attributable to non-recipients and/or other state or Federal non-Medicaid programs. While the cost apportionment process can be complicated, this does not always constitute an additional barrier, because some organizations must do cost-apportionment in any case whenever they receive Federal funds for administering non-Medicaid programs.

- Thus, administrative claiming can be especially advantageous for states that operate a single point of entry system through human service authorities that also administer the provision of non-Medicaid benefits. Minnesota, for example, uses administrative claiming with respect to its county human service agencies

for a range of case management functions that are not specifically covered under the case management service for waiver beneficiaries (e.g., eligibility determination; administrative functions involving case managers such as program planning, development and outreach; and certain licensing and contracting functions).

- When points of entry are organized along target population lines, administrative claiming may be used to avoid some of the problems associated with service-based claiming, especially when most of the individuals receiving services are Medicaid-eligible in any case.

- Administrative claiming is consistent with models where a state has established, by law or regulation, a distinct network of local point-of-entry / case management authorities.

- In addition to helping a state underwrite the costs of its point of entry / service coordination system, administrative claiming can play an important role in helping states operate their home and community service systems through activities that are not keyed to meeting the needs of specific consumers (such activities can be conducted directly by the Medicaid state agency or provided by a vendor). Such activities include:

  — Outreach to make individuals and families aware of the availability of home and community services.

  — Quality assurance / quality improvement activities associated with the delivery of Medicaid home and community services.

  — Automated data systems to compile a wide range of information concerning beneficiaries of home and community services, including data to support quality improvement activities or aid in strategic planning.

  — "Hot lines" and similar administrative activities to aid beneficiaries in locating services or registering complaints.

  — Various state-level administrative systems activities—including conducting state-level review and approval of HCBS waiver plans of care and other types of service plans, operating payment systems, determining provider rates, responding to consumer complaints, and conducting service quality reviews.

- The administrative claiming option for case management activities provides states with the capability of securing FFP for external case management services furnished to institutionalized persons that does not hinge on whether the person's discharge from the facility is imminent. Administrative claiming may be employed to provide external oversight of the well-being of institutionalized persons as well as support "in-reach" activities to provide information concerning the availability of home and community services.

  Administrative claiming may also span case management activities that are directly tied to arranging and assisting a person's return to the community without respect to length of time involved. However, such activities must be tied to arranging Medicaid home and community services. The state Medicaid agency may obtain case management services for institutionalized persons via contract with a state program office or through local human services agencies. Organizing case management for institutionalized persons under the administrative claiming option may simplify use of Medicaid dollars to underwrite such services in comparison to other available service options.

Drawbacks to states of using administrative claiming for case management services:

- Federal reimbursement of administrative expenses is generally limited to 50 percent of allowable costs. In states where the service rate is greater than 50 percent, administrative claiming will yield less FFP.

- Administrative claiming is limited to activities related solely to administration of the Medicaid plan. Thus, the costs of activities that

assist individuals to access other sources of assistance have to be met out of state/local dollars. Alternatively, states can use the targeted case management option to cover these activities.

- Individuals lose the protections contained in Medicaid law with respect to provider freedom of choice, since administrative claiming usually restricts service coordination activities to a single provider source.

States May Use One, Two, or All Three of the Case Management Alternatives

Federal policy leaves it up to states to select the options or combinations of options that will be most effective in meeting the needs of individuals and families with long-term care needs. Federal policy does prohibit states from claiming the costs of the same activity of service coordination for the same individual under more than one alternative at the same time. But as long as this prohibition is observed, a state can use the three options to serve recognizably different purposes. For example, a state may combine service coordination as a distinct service for participants under HCBS waivers with targeted case management services for Medicaid recipients not being served by the waiver program. This allows the state to offer case management services under its state plan that are more limited in scope than those offered under an HCBS waiver.

Wyoming takes advantage of this possibility by offering targeted case management to individuals wait-listed for HCBS waiver services, in order to assist them in connecting with other sources of direct service assistance while awaiting waiver coverage. Sometimes a state may want to add administrative claiming to the case management mix. Although administrative claiming may not be used to assist recipients in accessing non-Medicaid services, it has the advantage of allowing FFP claiming for certain services that are not claimable under targeted case management or an HCBS waiver—including outreach, quality assurance/quality improvement, operating automated data systems, and various state-level administrative activities.

Coverage of Assisted Living for Elderly Persons: Illustration #2

It has long been recognized that, in order to reduce institutionalization, it is necessary to develop a range of residential options that provide supportive services. Given a choice, most people with long-term care needs would prefer to receive services in their own homes. However, some people prefer to live in residential settings other than their homes for a variety of reasons—such as the desire to have someone available 24 hours a day to meet unscheduled or emergency needs because they feel safer in such a setting. This preference is reflected in the recent private-sector growth in various forms of supported housing arrangements (called assisted living or residential care) for persons age 65 and older.

Services covered by or in an assisted living facility are governed by state law and regulations. There are no applicable Federal statutes, other than the Keys Amendment to the Social Security Act, which is applicable to board and care facilities in which a "substantial number of SSI recipients" are likely to reside.[6] State rules vary widely, and many are currently being updated because assisted living is a relatively new concept, not envisioned by many state legislatures or rulemaking bodies in the past.

Using Medicaid to pay for services in assisted living settings for elderly persons is of increasing interest to states looking to offer a full array of home and community services and to reduce nursing home use. By 2000, 35 states were using Medicaid to reimburse services to support assisted living for people with long-term service and support needs.[7] Twenty-four states cover services in assisted living settings under 1915(c) waivers; six cover it in their state plans through the personal care option; three cover it in both the waiver and the personal care option; one covers it through an 1115 waiver; and one covers it under a 1915(a) waiver.[8]

Assisted living may refer to a generic concept that covers a wide array of settings and services, or to a very specific model—or both—depending on who is using the term.[9] Twenty-nine states have a licensing category called assisted living, each with

its own definition.[10] Assisted living is also often used as a marketing term for facilities that may be licensed under another category, such as residential care facilities and personal care homes. The term is even used by facilities that are not licensed to provide services but whose residents receive services provided by outside agencies. As discussed in Chapter 4, HCFA includes a definition of assisted living in the standard HCBS waiver application, but states have the option to use a different definition. (See Appendix I for the full text of HCFA's definition.)

Assisted living is used here to mean *care that combines housing and supportive services in a homelike environment and seeks to promote maximal functioning and autonomy*. Medicaid will pay for services provided in assisted living facilities as long as the "homelike environment" is preserved. Thus, Medicaid will not pay for assisted living services if the assisted living facility is located in the wing of a nursing home (or ICF/MR). Emergence of assisted living as a residential rather than an institutional model—combined with changes in state licensing regulations—has provided many people who need supportive and health services with an important alternative to the nursing home. This type of living arrangement is very popular among private-pay older persons and their families. Covering assisted living through Medicaid provides safety net funding for this group, many of whom may one day be unable to afford it out of their own resources.

The logistics of setting up an assisted living program can be quite complex. Most important is the recognition that assisted living is more than just a setting for potentially cost-effective service delivery. It represents a philosophical approach to residential services that supports independent living, autonomy, and consumer choice—a philosophy that should guide decisionmaking for regulations and payment policy. In making such decisions, states must address a number of key issues, each of which is discussed in turn.

Target Population

Determining what population will be served will depend in large part on the state's current long-term care system and its policy goals. Is assisted living intended to fill a gap in the current set of options? Will the target population be different from the population usually served in board and care facilities? Is assisted living intended to enable people who cannot be served in their homes to avoid institutionalization?

Once these questions are answered, the state must decide which age groups will be served, and whether services will be designed to address the specialized needs of specific populations (e.g., persons with dementia). It is also crucial to make certain that licensing and other facility regulations in a given state match the target population. For example, if the state wants to target nursing home-eligible beneficiaries, the assisted living facilities will need to be able to serve a population with a nursing home level of need.

Service Delivery Models

The definition of assisted living varies from state to state and sometimes from residence to residence. Some states have used regulations or licensing requirements to define assisted living services. States using Medicaid HCBS waivers define the service to suit the purpose of their particular program. A variety of service delivery models are possible. The assisted living residence may be the provider of services, for example, or the service provider may be a separate agency. Yet a third alternative is to consider the assisted living setting a person's *home*; this permits a state to provide home and community services to persons in assisted living through the existing delivery system.

Whatever the model chosen, it is important to note that assisted living in no way compromises a person's right to receive other Medicaid services. The overriding criterion for receipt of services under any model is medical necessity.

Personal Care Option or Waiver or Both?

States can cover assisted living services through either a waiver program or the personal care option under the state plan or both. The waiver approach is advantageous in that states can

Coverage of Assisted Living through the Waiver Program: Oregon[11]

Oregon's Division of Senior and Disabled Services/Department of Human Resources licenses, pays for, and places Medicaid beneficiaries in two settings: assisted living facilities (ALFs) and residential care facilities (RCFs). The state has two classes of RCFs: Class I facilities provide only ADL assistance. Class II RCFs offer a range of services and can serve people who need a nursing home level of care. The Medicaid waiver program covers services in Class II RCFs and ALFs.

RCFs and ALFs can serve the same population but they operate under different regulations. When Oregon decided to regulate assisted living, it chose not to replace existing RCF rules. Instead, it added a new licensing category for assisted living with requirements that differ somewhat from its RCF rules.

Target Population. The waiver program serves adults age 18 and older. Assisted living residents who become Medicaid-eligible and individuals at risk of nursing home placement are given priority for assisted living services. Rather than set specific medical or functional criteria governing when a resident is no longer appropriate for assisted living, Oregon's regulations permit discharge when the facility can no longer meet the resident's needs or there is a "documented established pattern" of noncompliance with the resident agreement.[12]

Setting. The primary difference between RCFs and ALFs is the physical setting. RCFs provide single or double rooms with shared baths; individual kitchens are not required. Assisted living is defined as a setting that promotes resident self-direction and decisions that emphasize choice, dignity, privacy, individuality, independence, and home-like surroundings. ALFs must offer individual apartments with lockable doors, kitchen facilities, and private baths.

Services. Each resident is assessed and receives services in accordance with an individual service plan. Assisted living regulations specify that an interdisciplinary team assess the resident's needs and develop a service plan to respond to those needs. The team includes the resident (or legal representative) and two or more of the following: program case manager, facility administrator or designee, and licensed nurse if the resident is or will be receiving nursing services.

Services provided by RCFs and ALFs include three meals a day, modified special diets, personal and other laundry, a program of social and recreational activities, assistance with ADLs, essential household services (cleaning, dusting, bed making), health care assessments, oversight and monitoring of health status, health care teaching and counseling, an emergency response system, and assistance with medications. Nursing tasks may be delegated.

Each facility must also be able to provide or arrange for medical and social transportation, ancillary services for medically related care, barber/beauty services, hospice, home health care, and maintenance of a personal financial account for residents.

Staffing. RCFs must meet a specific staff-to-resident ratio, which varies based upon the facility size. ALF regulations are more flexible, requiring an adequate number of qualified staff to meet the unique care, health, and safety needs of residents.

Payment. Oregon assesses ALF and RCF residents and assigns a payment level based upon the individual's need for assistance with ADLs. In 2000, ALF rates ranged from $628/month for the least impaired group (generally requiring assistance with two to three ADLs) to $1773/month for the most impaired group (generally dependent in three or more ADLs). Room and board payments of $433.70/month are the responsibility of the resident.

broaden eligibility by using the 300 percent of SSI rule to reach persons in the community who would not ordinarily meet the financial qualifications for Medicaid. (The 300 percent rule is explained briefly below and in detail in Chapter 2.) However, since waiver services are available only to beneficiaries who meet the state's nursing home level-of-care criteria, serving people through a waiver will target a more severely impaired population than is generally served through the personal care option. The waiver program also offers the advantage of predictable

Coverage of Assisted Living through the Personal Care Option: Arkansas[13]

Arkansas does not currently have a licensing category called "assisted living." The state licenses Residential Care Facilities (RCFs), a board and care setting available to both private-pay individuals and Medicaid beneficiaries. Since the mid-1980s, Arkansas has provided Medicaid personal care services to residents of RCFs.[14] The Arkansas Medicaid program uses personal care rather than waiver funding for assisted living coverage because the RCF licensing category does not permit a nursing home level of services. The state is currently developing a more comprehensive assisted living program that will serve a more disabled population and be funded through a Medicaid waiver program.

Target Population. Adults age 18 and over are served. Residents must be independently mobile (i.e., physically and mentally capable of vacating the facility within three minutes). Residents who can use canes, wheelchairs, or walkers are considered independently mobile if they do not need more than verbal or limited physical assistance to vacate. Residents must be able to self-administer medications. They may not need more than intermittent nursing, have feeding or intravenous tubes, or be totally incontinent. Residents also may not have mental incapacity (mental illness, dementia, substance abuse, etc.) that requires a higher level of treatment or care than the facility is capable of providing.[15]

Setting. RCFs provide single or double rooms without kitchen facilities. Resident access to a kitchen is not required because meals are provided. Bathrooms may be shared. There must be at least one lavatory for every 6 residents and one tub/shower for every 10 residents.

Services. RCFs provide personal care (assistance with bathing, grooming, and dressing), supportive services (guidance, direction, or monitoring), activities and socialization, meals, housekeeping, and laundry. Residents may choose the RCF or an outside agency to provide personal care services, thus ensuring the Medicaid beneficiary's right of provider choice. Home health agencies are used to provide nursing services.

Payment. Medicaid payment for personal care services is based on the number of service hours provided (fee-for-service). The state limits the number of hours per month to 64, but the limit can be overridden with prior approval. Room and board is paid with SSI benefits ($512 minus a personal needs allowance).

costs for states concerned about utilization of a new benefit. The combination of nursing facility level-of-care eligibility criteria, a set number of slots (as is permitted in a waiver program), and expenditure caps will limit the number of people potentially eligible.

The personal care option is advantageous in that it will broaden eligibility by allowing a less severely impaired population to be served. This is because states may impose reasonable medical necessity criteria but may not restrict the benefit to persons who require a nursing home level of care. One disadvantage of using the personal care option is that it lacks the higher income eligibility standard used for waiver programs. When deciding which approach to use—or whether to use both—states may want to estimate how many people would be served under the different options in order to judge both the reach of the potential service and its likely cost.

Type of Waiver

When using the waiver program approach, should states add assisted living as a new service to an existing waiver program or implement it under a separate waiver program? From one perspective, adding to an existing waiver program is simple and minimizes reporting and tracking requirements. However, advocates for home and community services may perceive the addition of assisted living to the list of waiver services already covered as increased competition for a limited number of slots available for home services more generally. Coverage under a separate waiver program may be a better approach, not only for this reason but also because it enables a state to test the demand for and cost-effectiveness of assisted living *per se*. Separate waiver programs designed by a state to expand the total number of people served under waiver programs may also make it easier to reassure facilities in that state that they will have access to a sufficient number of consumers. Since providers receive

Medicaid payments based on the number of beneficiaries they serve, facilities may be reluctant to participate in the Medicaid program at all if they are unsure they will have a reliable source of potential residents.

Level of Care and Licensing Rules

HCBS waiver regulations require that any facility in which waiver services are furnished must meet applicable state standards. When services are furnished by the assisted living facility, the facility must meet the standards for service provision that are set forth in the approved waiver documents. Thus, states planning to cover assisted living through a waiver program need to be sure that the admission/retention provisions of state licensing requirements permit assisted living facilities to serve individuals who meet Medicaid's nursing home level-of-care criteria. Licensing must also address a facility's qualifications to provide assisted living services. In a few states, the facilities do not themselves provide these services. Instead, outside agencies come into the facility to provide them. For example, Minnesota covers assisted living provided by outside agencies to residents of facilities that provide only room and board and limited supervision. In such cases, the facility may need to meet only minimal housing standards, while the outside agency may be held to state licensing and program standards for home care providers. Residents in such settings may be personally responsible for making arrangements with an outside agency for service delivery, or, more typically, the state may provide case management services to assist the resident in doing so.

States that use a waiver program to provide assisted living need to contract with facilities that are willing and able to provide the services needed by someone who meets the state's Medicaid nursing facility level-of-care criteria. The assisted living industry is perceived as generally serving people with lighter needs. For example, about one-quarter of assisted living residents need no assistance with ADLs, according to a recent study by the National Center for Assisted Living.[16] The same study found that 43 percent of residents who move out of assisted living enter nursing homes. To the extent that these statistics suggest an orientation toward serving a population that is less impaired than Medicaid waiver clients, facilities may not be capable of or willing to serve residents with greater needs.

Licensing and Contracting Issues

State licensing rules set the minimum requirements for Medicaid providers. The Medicaid program may set more stringent standards if desired, however. For example, some states allow facilities to offer rooms shared by two, three, or more residents. But since one of the purposes of assisted living is to foster independence and autonomy, some state Medicaid programs will only contract with facilities that offer private occupancy unless the resident chooses to share a room/unit. Some states also require facilities contracting with Medicaid to offer apartment-style units rather than bedrooms. (These include Oregon, Washington, and North Dakota.) Further, if licensing rules do not include sufficient requirements for facilities serving people with Alzheimer's disease, the Medicaid contracting requirements may specify additional training or other requirements.

Enabling Beneficiaries to Pay for Room and Board

Payment for room and board is one of the critical issues for states seeking to expand assisted living for Medicaid beneficiaries. Surveys by national associations have found that care in assisted living facilities may be unaffordable for many low-income individuals. Monthly fees in market rate facilities range from $800 to over $3500—with the majority in the $800–$2000 range. These fees vary by facility design and size of units and encompass amenities in addition to room and board. But assisted living facilities are marketed as a total package and people who are eligible for Medicaid cannot afford these fees.

Medicaid can be used to pay for assisted living *services*, but cannot pay for room and board. Except in very limited circumstances (such as a weekend stay provided as respite care under an HCBS waiver), the Medicaid beneficiary is

responsible for room or board costs, whether paid through pensions, savings, Social Security, or SSI.

States can and do use a number of approaches to ensure that the room and board rate for assisted living does not exceed the income available to Medicaid beneficiaries. These approaches include the following:

- States can examine the facility's monthly room and board charges to identify any coverable services—such as laundry assistance, light housekeeping, or food preparation—that can be reimbursed by Medicaid for a beneficiary who requires assistance with these IADLs. Including all coverable services in the state's assisted living service payment reduces the beneficiary's monthly payment solely to room and board and any other charges that Medicaid does not cover.

- Some states set only the service rate, leaving determination of the room and board rate to the facility. Florida and Wisconsin are examples of state Medicaid programs that set only the service rate. Beneficiaries choose among the assisted living facilities they can afford.

- Other states limit the room and board amount that can be charged to Medicaid beneficiaries. One option is to limit these costs to the amount of the Federal SSI payment rate. In the year 2000, that amount is $512 a month, which may be too low to provide a sufficient incentive for assisted living facilities to serve Medicaid beneficiaries.

- If the state has a State Supplemental Payment (SSP) program to supplement SSI payments, the assisted living room and board rate can be set at the amount that represents the Federal payment plus state payment. A few states have developed a supplemental payment rate specifically for beneficiaries in assisted living facilities, to provide them with sufficient income to afford the room and board component. Massachusetts has done this, for example, setting a payment standard of $966. The state uses its own funds to raise the Federal SSI payment to an amount sufficient for assisted living residents. (SSPs are discussed in detail in Chapter 2.)

- States are also exploring ways to provide assisted living services to residents of subsidized housing. Because subsidized housing is developed with tax credits and other specialized financing mechanisms, the rent component may be much lower than market rate and the resident may receive rental assistance that covers room and board costs. However, housing subsidy programs and Medicaid operate under very different rules. Careful planning and close collaboration is necessary to enable the programs to work together.

Assisted living and the special income limit: Post-eligibility treatment of income

Some states cover persons in an HCBS waiver program using the so-called 300 percent of SSI eligibility option (a person's income must be at or below 300 percent of the maximum SSI benefit—roughly $1500 per month.) This option is attractive for waiver programs that include assisted living, because it expands the program to include beneficiaries who are better able to afford the room and board costs of assisted living. To make this option effective, however, states must allow eligible persons to retain enough of their income to pay the room and board charges of an assisted living facility.

Medicaid beneficiaries who qualify under the 300 percent option are required to contribute toward the cost of their services. To determine the beneficiary's share of cost, the state must follow Medicaid rules governing post-eligibility treatment of income. These rules require states to set aside (protect) certain amounts of income for personal use and to assume the remainder is contributed to the cost of services. The state has the option to specify the amount of income that needs to be protected, and can take the costs of assisted living room and board into account when doing so. (See Chapter 2 for a detailed discussion of financial issues connected with the 300 percent option.)

Protecting sufficient income for room and board in assisted living, of course, reduces the amount the beneficiary pays toward the costs of services, thus raising service costs to the Medicaid program. When states are considering how much to protect, they need to balance this source of increased costs against the consequence of not

protecting sufficient income to pay room and board. In such a case, the beneficiary will not be able to afford room and board and share of service cost, and may be forced to move into a nursing home (where the room and board costs *are* covered by Medicaid).

Some states may be concerned about the fiscal impact of an across-the-board increase in the maintenance allowance. *But states are not required to increase the amount of income protected for all waiver beneficiaries who pay a share of cost in order to address the needs of beneficiaries who reside in assisted living*. States have the option to vary the amount of income that is protected based on the circumstances of a particular class of beneficiaries. For example, a beneficiary living alone may need to retain more income than a beneficiary living with a family member. A person living in an assisted living facility may have higher or lower need than a person living alone in a single-family home, or vice versa. Colorado, for example, allows people living in their home or apartment to retain nearly all their income and those living in personal care homes to retain an amount equal to the SSI benefit standard, which is the amount for room and board.

The state can further refine its treatment of income to account for variations in the cost of assisted living. Some states contract with both private (market rate) and subsidized assisted living facilities; the beneficiary's need for income will depend on the type of assisted living facility chosen. The "rent" component of the monthly fee charged by facilities built with low-income housing tax credits, for example, will be lower than the rent charged by privately financed facilities. If the state protects income based on the area's average monthly charge for room and board in private assisted living, the beneficiary living in a subsidized unit may be allowed to keep income that could be applied to service costs. But if income is protected based on the rent in subsidized units, beneficiaries may be allowed too little income to afford private market facilities. Setting a separate maintenance allowance for each setting allows a state to improve access to both private and subsidized assisted living facilities.

Income supplementation by family members or trusts for payment of room and board

When the beneficiary is unable to pay all room and board costs, family members may be willing to help pay them and other expenses not covered by Medicaid. A trust's funds may also be used to help pay for a beneficiary's costs not covered by Medicaid. However, families and trustees need to be aware of how any funds they contribute may affect beneficiaries' eligibility for various benefits (and therefore their net living standard). Any amount paid can reduce the recipient's SSI benefit—and in the worst-case scenario cause the recipient to lose SSI altogether, and with it potentially Medicaid as well. This is because SSI rules consider such supplementation in determining the individual's financial eligibility.

If the contribution is paid directly to the SSI beneficiary, it is counted as unearned income—the same as unearned income from any other source—and will reduce the individual's SSI benefit dollar for dollar. However, if the money is paid instead to the assisted living facility on a beneficiary's behalf, it is treated differently. SSI counts payment to the facility as "in-kind" income to the beneficiary and reduces the monthly Federal SSI benefit by up to one-third. Even if the "in-kind" contribution exceeds one-third of the SSI payment, the payment is only reduced by one-third. (See box.)

Medicaid rules follow SSI rules when families give money directly to an individual.[17] That is, the money counts as income just like any other unearned income. Therefore, if the individual is in a Medicaid eligibility group expected to pay a share of the cost of medical services, all a family cash supplement accomplishes is to increase the individual's share and decrease Medicaid's share of that cost. In some cases, as noted, such supplements can result in the individual losing eligibility altogether.

Medicaid also follows SSI rules regarding payments made by the family directly to a facility for room and board. These payments are counted as "in-kind" income, the dollar value of which is determined under special SSI rules. Thus, like a family payment made directly to the individual, the family's payment to the facility can affect

Effect of Income Supplementation on SSI Benefit

Assume that:

- Room and board charge is $800
- Individual has no income from other sources
- Full SSI benefit is $512
- The first $20 of unearned income is disregarded.

The difference between the SSI benefit and the room and board charge is $288. If the family pays $288 directly to the individual, this amount (minus the $20 disregard) is subtracted from the individual's SSI benefit, leaving only $264. The individual will be even less able to pay room and board costs than without the family's payment.

If the family pays $288 to the facility, then the individual's SSI benefit is reduced by *one-third* to $341. The family would then have to pay the difference between $341 and $800 (the room and board cost), which is $459. The consequence of the one-third reduction, then, is that the family must increase its supplementation from $288 to $459.

Because the rule states that the SSI payment will be reduced by *up* to one third, there is no limit on the amount of money that can be paid to a facility on behalf of the SSI beneficiary. If a family chooses, they can subsidize services other than room and board, as well as pay for room and board costs in more expensive facilities, without jeopardizing an individual's eligibility for SSI.

Medicaid eligibility as well as increase the individual's share of cost.

If families want to provide support to their family member who can cover room and board expenses, they should directly purchase anything other than food, clothing, and shelter. In an assisted living setting, for example, families could pay for any service not included in the facility rate or covered by Medicaid, such as cable television or personal phone service. In no such case may the state require supplementation.

Assisted Living and the Medically Needy

Medically needy beneficiaries are persons who, except for income, would qualify in one of the other Medicaid eligibility categories (such as being over age 65 or meeting the SSI disability criteria). Medicaid payments can begin for this group once they have spent down—that is, incurred expenses for medical care in an amount at least equal to the amount by which their income exceeds the medically needy income levels. (See Chapter 2 for additional discussion of this group and of medically needy income eligibility levels.)

The medically needy eligibility option can allow people who have income greater than 300 percent of SSI to become eligible for Medicaid services. But Federal law imposes two significant constraints on the use of this option:

- The state must cover medically needy children and pregnant women before it can elect to cover any other medically needy group. Additionally, the state may not place limits on who is eligible for Medicaid by using such characteristics as diagnosis or place of residence. Thus, it cannot use medically needy policies to extend Medicaid services only to HCBS waiver or assisted living beneficiaries.

- The maximum income eligibility limit that a state medically needy program may use is based upon its welfare program for families—levels that are typically lower than SSI. The income level must be the same for all medically needy groups in the state (i.e., states are not permitted to establish higher income eligibility levels for selected subsets of the medically needy, such as beneficiaries in assisted living settings).

These rules have several implications that states need to consider when trying to make the medically needy eligibility option work for higher income individuals in assisted living. (1) These individuals may find it more difficult to incur sufficient medical expenses to meet the spend-down requirements while living in the community than they would in a nursing home. The higher their "excess" income, the higher the amount of their spend-down—with the implication that only those with extremely high medical expenses may qualify. (2) Community providers are less willing to deliver services during the spend-down period, since payment cannot be guaranteed and collec-

tion may be difficult. (3) Spend-down rules combined with low medically needy income-eligibility levels mean that individuals may not have enough total income to pay both the bills they incur under the spend-down provision and the room and board component of assisted living. This is ironic since they start off with more income relative to other eligibility groups. As of the publication date, HCFA is actively examining this issue to find possible solutions (watch the HCFA website for updates).

Service Payment Rates: Adequacy Concerns

Unless the monthly rate is considered reasonable by assisted living facilities, they will not be willing to contract with Medicaid. In some states, rates in the $1500–$2500 a month range may be needed to attract enough facilities to serve Medicaid beneficiaries. When considering what rate might be necessary and reasonable, states might sample the rates charged by facilities (excluding very high end facilities) to assess (a) how they compare with Medicaid nursing home rates and (b) how many facilities might potentially contract with Medicaid at rates the state might be willing to pay.

It is also important for the state to be sensitive to the potential need to set payment levels that vary based on the assisted living residents' current needs. Doing so will enable people whose condition deteriorates to stay in the assisted living facility rather than having to move to a nursing home. A number of states use such tiered rates (including Arizona, Delaware, Oregon, and Washington). Rates set by case mix (as used in Minnesota, Maine, Wisconsin, and New York) also create incentives to accept people with high needs and retain people whose needs increase. Flat rates, in contrast, tend to force facilities to discharge residents whose needs exceed what can be covered under the rate.

As a final point, instead of reimbursing facilities on the basis of specific services delivered, states are permitted to develop a bundled monthly rate. A bundled rate is easier to administer for the state under a waiver program, and for providers under any coverage option.

Endnotes

1. The primary contributors to this chapter are Gary Smith, Janet O'Keeffe, Letty Carpenter, Robert Mollica, and Loretta Williams.

2. Mollica, R.L. (June 1998). *State assisted living policy: 1998.* Prepared for The Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and LongTerm Care Policy. Washington, DC: Department of Health and Human Services.

3. Case management activities are also covered routinely as a component of another service. For example, home health agencies that provide home health services are required to perform certain case management activities.

4. HCFA also clarifies that states can recoup the costs of service coordination furnished to individuals returning to the community through the HCBS waiver program when the person is enrolled in the HCBS waiver after discharge. As with targeted case management services, FFP is available for service coordination furnished during the 180-day period preceding institutional discharge. These service coordination activities are considered completed when the person enrolls in the waiver program.

5. The cost of HCBS waiver case management services can also be claimed at the service rate.

6. Section 1616(e) of the Social Security Act.

7. Some of these "assisted living" facilities may be termed "board and care," depending on the state.

8. Mollica, R.L. (June 1998). *State assisted living policy: 1998.* Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy. Also, personal communication, June 19, 2000.

9. Settings called Assisted Living Facilities (ALFs) differ widely; some provide a high degree of privacy and services consistent with the philosophy of assisted living; others provide very little privacy and few services. National Association of State Units on Aging. 1999. *Advocacy practices in assisted living. A manual for ombudsman programs.* Washington, DC: Author; Hawes, C., Rose, M., and Phillips, C.D. (1999). *A national study of assisted living for the frail elderly*. Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy.

10. Not all of these 29 states reimburse services for Medicaid beneficiaries. Some states reimburse for serv-

ices in facilities licensed as board-and-care facilities, and others have created assisted living as a Medicaid reimbursed service even though the state may not have an assisted living licensing category.

The comparability requirement does not permit states to deny personal care services to persons in board-and-care homes. However, states are not required to pay twice for the same service (i.e., if the board-and-care facility provides personal care services, the beneficiary would be unlikely to demonstrate a medical need for personal care services from another provider and therefore would not be eligible for services).

11. Loretta Williams, National Association of State Units on Aging, with data from Mollica, R.L. (June 1998). *State assisted living policy: 1998.* Prepared for The Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy. Washington, DC: Department of Health and Human Services.

12. Residents may be asked to leave under the following conditions: (a) their needs exceed the level of ADL services provided by the facility; (b) the resident's behavior interferes with the rights and well-being of others; (c) the resident has severe cognitive decline and is not able to respond to instructions, recognize danger, or make basic care decisions; or (d) the resident has a medical condition that is complex, unstable, or unpredictable and appropriate treatment cannot be provided.

13. Loretta Williams, National Association of State Units on Aging, with data from Mollica, R.L. (June 1998). *State assisted living policy: 1998.* Prepared for The Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy. Washington, DC: Department of Health and Human Services.

14. An RCF is both (a) a setting in which personal care is provided and (b) a provider of personal care services. Arkansas allows personal care services to be provided in a person's home or other setting, such as an RCF. The state also allows RCFs to enroll in Medicaid as providers of personal care services. About 1500 Medicaid beneficiaries live in Arkansas RCFs.

15. The flexible standard used in Arkansas allows a person with mental impairments to be served in an RCF if the facility is capable of providing the necessary care and the individual's physician agrees that the setting is appropriate.

16. National Center for Assisted Living (1998). *Facts and trends: The assisted living sourcebook.* Washington, DC: Author. Some information on this report is on the website: www.ncal.org.

17. This discussion focuses on payments by family members. However, payments may also be made by a special needs trust on behalf of its named beneficiary. Many families set up such trusts for adult children with disabilities to ensure that they will be adequately taken care of throughout their lives.

Annotated Bibliography

National Association of State Units on Aging (NASUA) (1999). *Advocacy practices in assisted living: A manual for ombudsman programs*. Washington, DC: Author. (122 pages)

Developed specifically to provide technical assistance to ombudsmen, this manual contains information that will be useful to policymakers who are developing assisted living regulations or publicly funded assisted living programs. Included in the manual are an overview of assisted living trends and regulatory developments, benchmarks and a self-assessment questionnaire, an inventory of good practices and advocacy initiatives, and a list of assisted living resources. *The publication is avail-*